		FOR OHF USE					

LL1

2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0043174

Facility Name: Sovereign HealthCare

Address: 6159 N. Kenmore Ave (Number) Chicago (City) 60660 (Zip Code)

County: Cook

Telephone Number: (773) 761-9050 **Fax #** (773) 761-9055

IDPA ID Number: 364183687001

Date of Initial License for Current Owners: 10/01/1997

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Sanford B Alper **Telephone Number:** (847) 580-4100

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2004 to 12/31/2004 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title) Sanford B Alper - Principal
Kessler, Orlean, Silver & Co. P.C.
(Firm Name & Address) 1101 Lake Cook Road. Suite C
Deerfield, Illinois 60015-5233
(Telephone) (847) 580-4100 Fax # (847) 580-4199

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Sovereign HealthCare # 0043174 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 55

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	55	Intermediate (ICF)	55	20,130	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	55	TOTALS	55	20,130	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	17,348	116		17,464	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	17,348	116		17,464	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.76%

D. How many bed-hold days during this year were paid by Public Aid?
65 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 10/01/1997

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 10/01/1997 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified ____ and days of care provided 0

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2004 Fiscal Year: 12/31/2004

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Sovereign HealthCare # 0043174 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	122,151	9,999	5,520	137,670		137,670	4,212	141,882			1
2	Food Purchase		50,202		50,202	(10,749)	39,453		39,453			2
3	Housekeeping	30,803	7,163		37,966		37,966		37,966			3
4	Laundry		3,569		3,569		3,569		3,569			4
5	Heat and Other Utilities			33,833	33,833		33,833	764	34,597			5
6	Maintenance			21,757	21,757		21,757	6,784	28,541			6
7	Other (specify):* See Attached Sch.			5,127	5,127		5,127		5,127			7
8	**TOTAL General Services**	152,954	70,933	66,237	290,124	(10,749)	279,375	11,760	291,135			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	374,606	982	35,568	411,156		411,156	58	411,214			10
10a	Therapy											10a
11	Activities	21,240	458	9,165	30,863		30,863		30,863			11
12	Social Services	7,393		20,897	28,290		28,290		28,290			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	403,239	1,440	65,630	470,309		470,309	58	470,367			16
	C. General Administration											
17	Administrative	50,640		71,096	121,736		121,736	(38,115)	83,621			17
18	Directors Fees											18
19	Professional Services			48,132	48,132		48,132	30	48,162			19
20	Dues, Fees, Subscriptions & Promotions			14,976	14,976		14,976	(950)	14,026			20
21	Clerical & General Office Expenses			7,987	7,987		7,987	19,209	27,196			21
22	Employee Benefits & Payroll Taxes			108,899	108,899	10,749	119,648	6,450	126,098			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,620	1,620		1,620		1,620			24
25	Other Admin. Staff Transportation							42	42			25
26	Insurance-Prop.Liab.Malpractice			75,978	75,978		75,978	271	76,249			26
27	Other (specify):*											27
28	**TOTAL General Administration**	50,640		328,688	379,328	10,749	390,077	(13,063)	377,014			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	606,833	72,373	460,555	1,139,761		1,139,761	(1,245)	1,138,516			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Sovereign HealthCare #0043174 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			8,997	8,997		8,997	2,586	11,583			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			363	363		363		363			32
33	Real Estate Taxes			37,767	37,767		37,767		37,767			33
34	Rent-Facility & Grounds			180,660	180,660		180,660		180,660			34
35	Rent-Equipment & Vehicles			900	900		900	151	1,051			35
36	Other (specify):*											36
37	**TOTAL Ownership**			228,687	228,687		228,687	2,737	231,424			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		1,409		1,409		1,409		1,409			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			30,195	30,195		30,195		30,195			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		1,409	30,195	31,604		31,604		31,604			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	606,833	73,782	719,437	1,400,052		1,400,052	1,492	1,401,544			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Sovereign HealthCare # 0043174 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	2,538	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(1,046)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 1,492		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 1,492		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

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Sovereign HealthCare

ID# **0043174**

Report Period Beginning: **01/01/2004**

Ending: **12/31/2004**

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Franchise Tax	$ (42)	21	1
2	Franchise Tax - Management Company	(6)	21	2
3	Non Deductible Dues	(998)	20	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(1,046)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Sovereign HealthCare # 0043174 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	4,212	0	0	0	0	0	0	0	0	4,212	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	764	0	0	0	0	0	0	0	0	0	764	5
6	Maintenance	0	296	6,488	0	0	0	0	0	0	0	0	6,784	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	1,060	10,700	0	0	0	0	0	0	0	0	11,760	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	58	0	0	0	0	0	0	0	0	58	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	58	0	0	0	0	0	0	0	0	58	16
	C. General Administration													
17	Administrative	0	0	(38,115)	0	0	0	0	0	0	0	0	(38,115)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	30	0	0	0	0	0	0	0	0	0	30	19
20	Fees, Subscriptions & Promotions	(998)	48	0	0	0	0	0	0	0	0	0	(950)	20
21	Clerical & General Office Expenses	(48)	129	19,128	0	0	0	0	0	0	0	0	19,209	21
22	Employee Benefits & Payroll Taxes	0	6,450	0	0	0	0	0	0	0	0	0	6,450	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	42	0	0	0	0	0	0	0	0	42	25
26	Insurance-Prop.Liab.Malpractice	0	271	0	0	0	0	0	0	0	0	0	271	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(1,046)	6,928	(18,945)	0	0	0	0	0	0	0	0	(13,063)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(1,046)	7,988	(8,187)	0	0	0	0	0	0	0	0	(1,245)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Sovereign HealthCare # 0043174 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	2,538	0	48	0	0	0	0	0	0	0	0	2,586	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	151	0	0	0	0	0	0	0	0	0	151	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	2,538	151	48	0	0	0	0	0	0	0	0	2,737	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,492	8,139	(8,139)	0	0	0	0	0	0	0	0	1,492	45

Facility Name & ID Number Sovereign HealthCare # 0043174 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES

A. **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.**

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Marvin Mermelstein	46.00%	Balmoral Home, Inc.	Chicago, IL	Nivram Mgmt, Inc.	Chicago, IL	Management
Phillip Esformes	36.00%	Central Home, Inc.	Chicago, IL			
Rachel Esformes	6.50%	RREM, Inc. d/b/a Winston Manor Nursing Home	Chicago, IL			
Rebecca Rosenbloom	6.50%	Chicago Ridge Nursing & Rehab Center	Chicago Ridge, IL			
Edward Burke, Jr.	5.00%					

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	21	Bank Charges	$	Nivram Management, Inc.	50.00%	$ 7	$ 7	1
2	V	21	Office Expense		Nivram Management, Inc.	50.00%	116	116	2
3	V	20	Dues & Subscriptions		Nivram Management, Inc.	50.00%	48	48	3
4	V	21	Franchise Tax		Nivram Management, Inc.	50.00%	6	6	4
5	V	19	Accounting		Nivram Management, Inc.	50.00%	30	30	5
6	V	22	Payroll Taxes		Nivram Management, Inc.	50.00%	5,676	5,676	6
7	V	5	Utilities		Nivram Management, Inc.	50.00%	764	764	7
8	V	26	Insurance		Nivram Management, Inc.	50.00%	271	271	8
9	V	6	Repairs & Maintenance		Nivram Management, Inc.	50.00%	185	185	9
10	V	22	Health Insurance		Nivram Management, Inc.	50.00%	774	774	10
11	V	6	Scavenger		Nivram Management, Inc.	50.00%	22	22	11
12	V	35	Rental Equipment		Nivram Management, Inc.	50.00%	151	151	12
13	V	6	Building Expense		Nivram Management, Inc.	50.00%	89	89	13
14	Total			$			$ 8,139	$ * 8,139	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Sovereign HealthCare # 0043174 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	25	Auto Expense	$	Nivram Management, Inc.	50.00%	$ 42	$ 42	15
16	V	21	Postage		Nivram Management, Inc.	50.00%	113	113	16
17	V	10	Matress Expense		Nivram Management, Inc.	50.00%	58	58	17
18	V	30	Depreciation		Nivram Management, Inc.	50.00%	48	48	18
19	V	21	Data Processing		Nivram Management, Inc.	50.00%	114	114	19
20	V	21	Telephone		Nivram Management, Inc.	50.00%	312	312	20
21	V	6	Plant Supervisor Salary		Nivram Management, Inc.	50.00%	6,488	6,488	21
22	V	17	Asst Administrator Salary		Nivram Management, Inc.	50.00%	9,732	9,732	22
23	V	21	Office Manager Salary		Nivram Management, Inc.	50.00%	4,370	4,370	23
24	V	1	Food Service Supervisor Salary		Nivram Management, Inc.	50.00%	4,212	4,212	24
25	V	17	Administrative Salaries		Nivram Management, Inc.	50.00%	23,249	23,249	25
26	V	21	Clerical Salaries		Nivram Management, Inc.	50.00%	14,219	14,219	26
27	V	17	Management Fees	71,096	Nivram Management, Inc.	50.00%		(71,096)	27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 71,096			$ 62,957	$ * (8,139)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Sovereign HealthCare # 0043174 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week Hours	Percent	Compensation Included in Costs for this Reporting Period** Description	Amount	Schedule V. Line & Column Reference	
1	Marvin Mermelstein	Asst. Administrator	Administrative	46.00%	163,500	1	5.95%	Salary	$ 9,732	L 17, Col 7	1
2	Marvin Mermelstein	Plant Supervisor	Support	See Above	109,000	2	5.95%	Salary	6,488	L 6, Col 7	2
3	Doreen Meremlstein	Office Manager	Support	0.00%	104,120	1	4.20%	Salary	4,370	L 21, Col 7	3
4	Henry Mermelstein	Administrative	Administrative	0.00%	250,000	3	3.24%	Salary	8,100	L 17, Col 7	4
5	Louise Mermelstein	Food Service Superv	Support	0.00%	90,000	3	4.68%	Salary	4,213	L 1, Col 7	5
6	Joseph Mermelstein	Administrative	Administrative	0.00%	95,000	0	0.00%	Salary	0		6
7											7
8			See Attached Schedule								8
9											9
10											10
11											11
12											12
13								TOTAL	$ 32,903		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Sovereign HealthCare # 0043174 Report Period Beginning: 01/01/2004 Ending: 2/31/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Nivram Management, Inc.
Street Address: 6500 N. Hamlin Ave
City / State / Zip Code: Lincolnwood, IL 60712
Phone Number: (847) 679-7484
Fax Number: (847) 679-7494

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	21	Bank Charges	Resident Beds	924	5	$ 110	$	55	$ 7	1
2	21	Office Expenses	Resident Beds	924	5	1,952		55	116	2
3	20	Dues & Subscriptions	Resident Beds	924	5	810		55	48	3
4	21	Franchise Tax	Resident Beds	924	5	100		55	6	4
5	19	Accounting	Resident Beds	924	5	510		55	30	5
6	22	Payroll Taxes	Resident Beds	924	5	95,359		55	5,676	6
7	5	Utilities	Resident Beds	924	5	12,827		55	764	7
8	26	Insurance	Resident Beds	924	5	4,558		55	271	8
9	6	Repairs & Maintenance	Resident Beds	924	5	3,103		55	185	9
10	22	Health Insurance	Resident Beds	924	5	13,008		55	774	10
11	6	Scavenger	Resident Beds	924	5	370		55	22	11
12	35	Rental Equipment	Resident Beds	924	5	2,544		55	151	12
13	6	Building Expense	Resident Beds	924	5	1,500		55	89	13
14	25	Auto Expense	Resident Beds	924	5	706		55	42	14
15	21	Postage	Resident Beds	924	5	1,895		55	113	15
16	10	Matress Expense	Resident Beds	924	5	967		55	58	16
17	30	Depreciation	Resident Beds	924	5	808		55	48	17
18	21	Data Processing	Resident Beds	924	5	1,914		55	114	18
19	21	Telephone	Resident Beds	924	5	5,238		55	312	19
20	6	Plant Dupervisor Salary	Direct Cost	1	1	6,488	6,488	1	6,488	20
21	17	Asst Administrator Salary	Direct Cost	1	1	9,732	9,732	1	9,732	21
22	21	Office Manager Salary	Direct Cost	1	1	4,370	4,370	1	4,370	22
23	1	Food Service Supervisor Salary	Direct Cost	1	1	4,212	4,212	1	4,212	23
24	17	Administrative Salary	Direct Cost	1	1	23,249	23,248	1	23,249	24
25	TOTALS					$ 196,330	$ 48,050		$ 56,877	25

Facility Name & ID Number Sovereign HealthCare # 0043174 Report Period Beginning: 01/01/2004 Ending: 2/31/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Nivram Management, Inc.
Street Address: 6500 N. Hamlin Ave.
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Phone Number: (847) 679-7484
Fax Number: (847) 679-7494

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	21	Clerical Salaries	Direct Cost	1	1	$ 14,219	$ 14,219	1	$ 14,219	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 14,219	$ 14,219		$ 14,219	25

Facility Name & ID Number Sovereign HealthCare # 0043174 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Ford Credit		X	Auto Loan	$382.00	10/12/03	$ 20,775	$ 6,995	7/12/06	3.9000	$ 363	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$382.00		$ 20,775	$ 6,995			$ 363	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 20,775	$ 6,995			$ 363	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Sovereign HealthCare # 0043174 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2003 report.	$	4,534	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	42,301	2
3. Under or (over) accrual (line 2 minus line 1).	$	37,767	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)	$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	37,767	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1999	49,982	8
2000	45,864	9
2001	47,057	10
2002	47,584	11
2003	46,301	12

Sovereign Health Care is leasing the building. The real estate tax liability is accrued for the difference between actual payments and the 2003 tax bill, paid in 2004.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Sovereign HealthCare COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0043174

CONTACT PERSON REGARDING THIS REPORT Sanford B Alper

TELEPHONE (847) 580-4100 FAX #: (847) 580-4199

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	14-05-210-003-0000	Sovereign Home	$ 46,301.00	$ 46,301.00
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 46,301.00	$ 46,301.00

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

Facility Name & ID Number Sovereign HealthCare # 0043174 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 6,000 B. General Construction Type: Exterior Brick Frame Metal Number of Stories 2

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred:
2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization:
4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$	1
2					2
3	TOTALS			$	3

Facility Name & ID Number Sovereign HealthCare # 0043174 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	55				$ (18,559)	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Air Conditioner			1998	4,579	117	39	117		760	9
10	Plumbing			1998	575	58	39	58		453	10
11	Elevator Repair			1998	2,300	59	39	59		384	11
12	Remodeling all Bathroom, New Tile			1998	79,929	2,049	39	2,049		13,644	12
13	Hot Water Heater			1998	2,625	67	39	67		436	13
14	Time Clock			1998	650	17	39	17		110	14
15	Remodeling Labor			1998	10,162		39	131	131	1,047	15
16	Remodeling Cost & Labor			1999	25,138	645	39	645		3,205	16
17	Remodeling Labor			1999	9,799		39	251	251	1,506	17
18	Door			1999	760	19	39	19		104	18
19	Tile Work			1999	2,294	58	39	58		323	19
20	Alarm			1999	3,000	77	39	77		423	20
21	Smoke Eaters			1999	1,452	38	39	38		204	21
22	Fire Alarm System			2000	45,132	900	39	627	(273)	3,665	22
23	Roof Repair			2001	1,500	38	39	38		114	23
24	Door Replacement			2001	1,072	27	39	27		91	24
25	Florescent Lighting			2003	840	21	39	21		30	25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Sovereign HealthCare # 0043174 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 173,248	$ 4,190		$ 4,299	$ 109	$ 26,499	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Sovereign HealthCare # 0043174 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 27,519	$ 1,688	$ 2,752	$ 1,064	10	$ 14,117	71
72	Current Year Purchases	2,425	1,344	243	(1,101)	10	243	72
73	Fully Depreciated Assets							73
74	Management Company		48	134	86	10	246	74
75	TOTALS	$ 29,944	$ 3,080	$ 3,129	$ 49		$ 14,606	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Administrative	2001 Ford Taurus	2001	$ 20,775	$ 1,775	$ 4,155	$ 2,380	5	$ 16,620	76
77										77
78										78
79										79
80	TOTALS			$ 20,775	$ 1,775	$ 4,155	$ 2,380		$ 16,620	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 223,967	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 9,045	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 11,583	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 2,538	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 57,725	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Sovereign HealthCare # 0043174 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: ABE Management L.L.C.

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [ ] YES [X] NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	1955	55	09/30/97	$ 218,427			3
4	Additions							4
5								5
6								6
7	TOTAL		55		$ 218,427 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: [X] YES [ ] NO Terms: Annual Lease *

10. Effective dates of current rental agreement:
Beginning 01/01/2004
Ending 12/31/2004

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ 1,051 Description: Ice Maker - $900; Copier from Management Company - $151
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Sovereign HealthCare # 0043174 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number Sovereign HealthCare

STATE OF ILLINOIS
0043174 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Respiratory	L 39, Col 2					1,409		1,409	13
14	TOTAL			$		$	$ 1,409		$ 1,409	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

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XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2004 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 1,210	$ 1,210	1
2	Cash-Patient Deposits	9,952	9,952	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	269,578	269,578	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	11,085	11,085	6
7	Other Prepaid Expenses	2,351	2,351	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Due from prior owners	42,735	42,735	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 336,911	$ 336,911	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	161,488	161,488	15
16	Equipment, at Historical Cost	50,719	50,719	16
17	Accumulated Depreciation (book methods)	(63,258)	(63,258)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 148,949	$ 148,949	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 485,860	$ 485,860	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 28,943	$ 28,943	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	23,014	23,014	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	529,259	529,259	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 581,216	$ 581,216	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 581,216	$ 581,216	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (95,356)	$ (95,356)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 485,860	$ 485,860	48

*(See instructions.)

Facility Name & ID Number Sovereign HealthCare # 0043174 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (34,798)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (34,798)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(11,558)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(49,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (60,558)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (95,356)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Sovereign HealthCare # 0043174 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 1,363,318	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 1,363,318	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen	1,409	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,409	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	11,412	19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 11,412	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	160	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 160	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	**Miscellaneous**	8,194	28
28a	**Void Check to Cook County Collector**	4,000	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 12,194	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 1,388,493	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	290,124	31
32	Health Care	470,309	32
33	General Administration	379,263	33
	B. Capital Expense		
34	Ownership	228,752	34
	C. Ancillary Expense		
35	Special Cost Centers	1,409	35
36	Provider Participation Fee	30,195	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 1,400,052	40
41	**Income before Income Taxes (line 30 minus line 40)****	(11,559)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (11,559)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

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XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,011	2,163	$ 53,937	$ 24.94	1
2	Assistant Director of Nursing					2
3	Registered Nurses	4,284	4,597	83,034	18.06	3
4	Licensed Practical Nurses	3,158	3,456	56,678	16.40	4
5	Nurse Aides & Orderlies	19,226	20,348	180,957	8.89	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,044	2,209	21,240	9.62	9
10	Activity Assistants					10
11	Social Service Workers	709	731	7,393	10.11	11
12	Dietician					12
13	Food Service Supervisor	2,058	2,194	21,089	9.61	13
14	Head Cook					14
15	Cook Helpers/Assistants	11,664	12,548	101,062	8.05	15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers	3,226	3,525	30,803	8.74	18
19	Laundry					19
20	Administrator	2,091	2,291	50,640	22.10	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	50,471	54,062	$ 606,833 *	$ 11.22	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	M	$ 5,520	1-3	35
36	Medical Director	O			36
37	Medical Records Consultant	N	9,825	10-3	37
38	Nurse Consultant	T	24,297	10-3	38
39	Pharmacist Consultant	H	1,446	10-3	39
40	Physical Therapy Consultant	L			40
41	Occupational Therapy Consultant	Y			41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	F			43
44	Activity Consultant	E	9,165	11-3	44
45	Social Service Consultant	E	20,897	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 71,150		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Susan Lippert	Administrator	0.00%	$ 50,640
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 50,640

B. Administrative - Other

Description	Amount
Management Fees	$ 71,096
TOTAL (agree to Schedule V, line 17, col. 3)	$ 71,096
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Klafter and Burke	Legal	$ 6,972
Howard Reich	Legal	1,350
Lawrence Y. Schwartz, Ltd	Legal	12,500
Personnel Planners, Inc.	U/C Consulting	393
Commitment Consulting, LLC	Collection Consulting	6,863
Systematic Management Syst	Billing Consulting	2,411
Kessler, Orlean Silver & Co	Accounting	11,350
Automatic Data Processing	Computer Payroll Service	1,800
Health Data Systems, Inc.	Computer Support	1,665
Medifax-Edi, Inc.	Computer Support	188
Accu-Med Services, Inc.	Computer Support	2,640
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 48,132

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 12,703
Unemployment Compensation Insurance	10,104
FICA Taxes	46,340
Employee Health Insurance	34,728
Employee Meals	10,749
Illinois Municipal Retirement Fund (IMRF)*	
Other Employee Benefits	5,024
Allocation from Management Company	6,450
TOTAL (agree to Schedule V, line 22, col.8)	$ 126,098

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,500
Advertising: Employee Recruitment	6,840
Health Care Worker Background Check	
(Indicate # of checks performed)	
City of Chicago Dept of Rev	1,455
Secretary of State	1,778
IL Concil on Long Term Care	2,978
See Attached Schedule	425
Allocation from Management Comp	48
Less Non-Deductible Dues	(998)
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 14,026

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,620
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,620

* Attach copy of IMRF notifications

**See instructions.

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XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Sovereign HealthCare # 0043174 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IL Council on Long - Term Care $2,978**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **0** Line

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **Yes**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **30,195**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **Yes** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **N/A**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **10,749** Has any meal income been offset against related costs? **No** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **0**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **N/A** If no, please explain. **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees